| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 006205 | A. BUILDING: _____ B. WING _____ | 10/17/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTHERN INDIANA REHABILITATION HOSPITAL | 3104 BLACKISTON BLVD NEW ALBANY, IN 47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>JCAHO<br>Surveyor: 33212<br>Facility Number: 006205<br><br>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey<br><br>Date of JCAHO On Site Survey - Hospital full survey 10/15-17/2013<br><br>Date of ISDH off site review - 1/7/ 2014<br><br>Reviewer/Surveyor -Nancy Otten, RN, PHNS<br><br>Based on review of the 10/15-17/2013 JCAHO Accreditation Survey Report, it has been determined that Southern Indiana Rehabilitation Hospital meets the requirements for Hospital Licensure in Indiana for 2013. | S 000 | | |